

Public Research Park Center

Medicare coverage of kidney dialysis and kidney transplant services

A supplement to
Your Medicare Handbook



PUBS
RA
645
K5
M43
975

Table of contents

Medicare and treatment for permanent kidney failure	3
Who is eligible for Medicare	3
When Medicare protection ends	4
The two parts of Medicare	5
Hospital insurance	5
Medical insurance	5
Who can provide maintenance dialysis and transplant surgery	6
Coverage of maintenance dialysis	6
Outpatient dialysis	7
Inpatient dialysis	7
Doctors' services and maintenance dialysis	8
Self-dialysis training	9
Home dialysis equipment	10
Supplies for home dialysis equipment	11
Kidney transplant surgery	12
What hospital insurance pays for	12
What medical insurance pays for	13
How Medicare pays for blood	14
What Medicare does not cover	15
Other payment sources	16

ORD INFORMATION
RESOURCES

4
5
5
43
75

Medicare and treatment for permanent kidney failure

This supplement to *Your Medicare Handbook* explains the special rules for Medicare coverage and payment of kidney dialysis and transplant services.

Medicare hospital insurance and medical insurance help pay for a wide range of other health services and supplies in addition to kidney dialysis and transplant services which are needed by people with permanent kidney failure.

If you have Medicare because of permanent kidney failure, you have the same protection that all other Medicare beneficiaries have.

Your Medicare Handbook describes the other health services and supplies that are covered by Medicare and how payments are made by each part of the program. If you don't have a copy of the handbook, you can get one at any social security office.

Who is eligible for Medicare

There are three groups of people who are eligible for Medicare:

- ▶ Almost all people age 65 or over, even if they are still working
- ▶ Disabled people under age 65 who have been entitled to social security disability payments for 24 consecutive months or who meet work requirements under the railroad retirement system
- ▶ Almost all people under age 65 with permanent kidney failure when they need maintenance dialysis treatments or a kidney transplant

To be eligible for Medicare under the kidney disease provision of the law, you must have worked long enough in a job under the social security or railroad retirement system or be the wife, husband, or dependent child of a worker with enough social security or railroad retirement work credits. **Only** the family member with permanent kidney failure is eligible for Medicare. Other members of the family are not.

When you become entitled to Medicare because of permanent kidney failure, Medicare coverage can begin either:

- ▶ the 1st day of the 3rd month after the month a course of maintenance dialysis treatments begins, or if earlier,
- ▶ the month you are admitted to an approved hospital and receive a kidney transplant or the month before the kidney transplant takes place if you are admitted to an approved hospital for the purpose of preparing you for the kidney transplant.

Anyone under age 65 with permanent kidney failure who is not now covered by Medicare should apply at any social security office.

When Medicare protection ends

The rules for whether Medicare coverage can end are different for each of the three groups of people entitled to Medicare. These rules are based on specific provisions in the Medicare law.

For people under age 65 who have Medicare because of permanent kidney failure, Medicare protection ends 12 months after the month they either no longer require maintenance dialysis treatments or receive a kidney transplant. However, if maintenance dialysis or another kidney transplant is needed during the 12-month period following kidney transplant surgery, Medicare coverage would continue.

Medical insurance can stop at any time for failure to pay premiums or if you decide to cancel.

People entitled to Medicare because they are 65 or over or disabled should refer to pages 46 and 47 of *Your Medicare Handbook* for information about events that can end their Medicare coverage.

The two parts of Medicare

As you read about Medicare coverage of kidney dialysis and transplant services, you should be familiar with the basic differences between the two parts of Medicare—hospital insurance and medical insurance. This section briefly describes coverage and payment under each part. For more detailed information, see *Your Medicare Handbook*.

Hospital insurance

Almost everyone who is eligible for Medicare is covered by hospital insurance without paying any monthly premiums.

Hospital insurance covers medically necessary inpatient hospital care and, under certain conditions, medically necessary post-hospital inpatient care in a skilled nursing facility and home health care. The hospital insurance part of Medicare, for example, helps pay for an inpatient stay in an approved hospital for kidney transplant surgery.

Hospital insurance has a \$92 deductible during calendar year 1975. The deductible must be met each time your admission to a hospital starts a new benefit period. Medicare payments for services covered by hospital insurance are made directly to the participating hospital, skilled nursing facility, and home health agency. (For more information about hospital insurance payments and benefit periods, see page 10 of *Your Medicare Handbook*.)

Medical insurance

All people eligible for Medicare can enroll in medical insurance. There is a monthly premium for everyone who has medical insurance. The current premium is \$6.70 per month. Many of the services and supplies needed by people with permanent kidney failure are covered **only** by medical insurance.

Medical insurance covers physicians' services, outpatient hospital services, outpatient physical therapy and speech pathology services, outpatient maintenance dialysis treatments in an approved dialysis facility, durable medical equipment for use in your home such as a kidney dialysis machine, as well as many other health services and supplies.

There is a \$60 deductible which must be met each year before payments can be made for services and supplies covered by medical insurance. The deductible can be made up of charges for any covered services and supplies. There is not a separate deductible for each covered service. After the \$60 annual deductible is met, medical insurance pays 80 percent of the recognized charges for covered services you receive during the rest of the year. (For more information about medical insurance payments, see pages 20 through 24 in *Your Medicare Handbook*.)

Who can provide maintenance dialysis and transplant surgery

To receive Medicare payments, medical facilities must be specifically approved to provide maintenance dialysis or kidney transplant surgery, regardless of whether they participate in Medicare to provide other health care services covered by hospital insurance and medical insurance.

They must meet special health, safety, and professional standards that are directly related to dialysis and kidney transplant services. They also must meet Federal, State, and local requirements for medical facility planning.

Your doctor or the facility can tell you whether a facility is approved by Medicare for payment of dialysis and transplant services.

Coverage of maintenance dialysis

This section explains coverage and payment for outpatient maintenance dialysis and the conditions under which inpatient dialysis is covered.

Outpatient dialysis

Medical insurance helps pay for outpatient maintenance dialysis treatments in any approved dialysis facility, including the costs of laboratory tests associated with your treatment and medical supervision provided by the facility during your treatment. Medical insurance payments for outpatient maintenance dialysis are always made to the facility.

Charges for maintenance dialysis will vary from one approved facility to another. The facilities' charges are based on their costs of providing dialysis treatments. The cost of treatment will depend on various factors such as costs of professional services and equipment in the area, the size of the facility, and other justifiable operating costs that can differ between one approved facility and another. A typical charge might be \$150 per treatment. In that case, if the \$60 annual deductible has already been met, medical insurance would pay 80 percent of \$150 (or \$120). Medicare **cannot** pay the remaining 20 percent of \$150 (or \$30).

Occasionally, maintenance peritoneal dialysis treatments will extend overnight. These extended peritoneal treatments are covered as outpatient services by medical insurance. Consequently, any overnight stays will not reduce the number of inpatient days covered by your hospital insurance unless you require inpatient care for additional specialized services.

Inpatient dialysis

Generally, maintenance dialysis treatments are covered on an outpatient basis. But if you are admitted to a hospital because your medical condition requires the availability of other specialized hospital services on an inpatient basis, your maintenance dialysis treatments would be covered by hospital insurance as part of the costs of your covered inpatient hospital stay.

Please refer to pages 12 through 14 of *Your Medicare Handbook* for a detailed explanation of the coverage of inpatient hospital care.

Doctors' services and maintenance dialysis

Doctors' services are covered by Medicare's medical insurance. While you are on maintenance dialysis, medical insurance can pay for your doctor's services in the following ways.

Your doctor can choose to receive a monthly payment for most of the services you will need during the month. Your doctor can use the monthly payment method whether your maintenance dialysis takes place in an outpatient dialysis facility or at home. When the monthly payment method is used, medical insurance pays 80 percent of the monthly fee minus any part of the \$60 annual medical insurance deductible that has not been met.

Certain additional services from your doctor which are not related to or not provided at the time of treatment of your kidney condition are not included in the monthly payment. For example, during a visit to your doctor for your kidney condition, you might receive services for bronchitis. All of the services you receive during this visit would be included in the monthly payment. But, any additional visits for follow-up care of the bronchitis would **not** be included in the monthly payment. Additional services of this kind are paid by medical insurance as explained in *Your Medicare Handbook*.

If your physician does not choose to use the monthly payment method and you are receiving dialysis treatments in an outpatient facility, your physician's services to oversee your dialysis will be included in the facility's bill for each dialysis treatment. These services include, for example, your doctor's review of your lab tests and being available to treat you, if necessary, while you are receiving dialysis treatments. When your doctor is paid in this way, any additional services—such as those needed to treat a complication that arises during dialysis—and services you need when you are not being dialyzed,

would be paid by medical insurance as described in *Your Medicare Handbook*.

If you self-dialyze—either in an outpatient facility or at home—and your doctor does not choose the monthly payment method, **all** of his services would be paid by medical insurance as described on pages 23 and 24 of *Your Medicare Handbook*.

Self-dialysis training

Self-dialysis can be the best way for some people to continue maintenance dialysis. These people, of course, need to be taught how to self-dialyze. If they will be dialyzing at home, the persons who will help them also need instruction. Self-dialysis training is covered by Medicare's medical insurance on an outpatient basis.

Coverage of self-dialysis training includes instruction of the patient and the person who will assist the patient with maintenance self-dialysis at home. Medicare **cannot** cover the cost of paid dialysis aides to assist self-dialysis patients at home.

In addition to instruction, medical insurance coverage of dialysis training includes the maintenance dialysis treatment and routine laboratory tests associated with the treatment.

Medicare **cannot** cover the costs of transportation to and from the outpatient dialysis center, lost wages of the patient being trained and the person assisting the patient, or cost of lodging during training.

Charges for self-dialysis training sessions may be higher than for dialysis treatments. While charges will vary from one dialysis facility to another, depending upon the type of facility and its geographic location, a typical charge might be \$170 per session. If the annual deductible has already been met, medical insurance would pay 80 percent of this charge (or \$136). Medicare **cannot** pay the remaining 20 percent of the charge (or \$34).

For the services of the doctor who is responsible for conducting all of your self-dialysis training, the maximum total charge medical insurance will recognize is \$500. If this maximum charge is made, medical insurance would pay 80 percent of \$500 (or \$400) if the deductible has already been met. Medicare **cannot** pay the remaining 20 percent (or \$100).

Home dialysis equipment

Medicare's medical insurance covers rental or purchase of kidney dialysis equipment for use in your home. Delivery and installation service charges are included as part of the charge recognized by medical insurance for home dialysis equipment.

After consulting with your doctor, you may decide either to buy or rent dialysis equipment. In either case, medical insurance makes monthly payments. If you decide to buy dialysis equipment, the monthly payment includes any interest or carrying charges that may be part of an installment purchase agreement with the supplier of the equipment.

After the \$60 annual deductible, medical insurance pays 80 percent of the recognized monthly rental charge or the recognized monthly installment purchase price for your home dialysis equipment.

Medical insurance payments for your home dialysis equipment can continue as long as you need to be dialyzed at home. If your need for home dialysis stops, these medical insurance payments also stop. For example, if you no longer need to be dialyzed because you have successful kidney transplant surgery, then medical insurance payments for your home dialysis equipment would usually stop.

If, however, you stop using your home dialysis equipment temporarily—for example, because you are traveling or are hospitalized—medical insurance will continue its payments for the equipment for up to 3 months after the month in which you last used the equipment. If at a later date you use the equipment again, medical insurance payments would also start again.

Of course, if you purchase your dialysis equipment, medical insurance payments always stop when the purchase price recognized as a basis for payments is reached.

Supplies for home dialysis equipment

Medical insurance also covers supplies needed in the operation of your home dialysis equipment. After the \$60 annual deductible is met, medical insurance pays 80 percent of the recognized charge for each package of medical supplies used in connection with your home dialysis treatments.

Coverage of supplies **cannot** include first-aid items such as alcohol and gauze that you buy separately from your home dialysis supplies. Also, blood (or packed red blood cells) **cannot** be covered for home dialysis unless your physician administers it or personally directs its administration, or the blood is needed to prime your dialysis equipment. (See “How Medicare pays for blood” on page 14.)

Kidney transplant surgery

Both parts of Medicare help pay for kidney transplant surgery.

What hospital insurance pays for

Medicare's hospital insurance covers your inpatient hospital services in an approved hospital when you are admitted for kidney transplant surgery. Hospital insurance also covers hospital services in preparation for your kidney transplant. This includes the Kidney Registry fee and services such as laboratory and other tests that are required to evaluate your medical condition and the medical conditions of potential kidney donors. These preparatory services are covered whether they are done by the approved hospital where your transplant surgery will take place or by another hospital that participates in Medicare. If there is no kidney donor, the costs of obtaining a suitable kidney for your transplant surgery are also covered.

When your admission to an approved hospital for transplant surgery starts a benefit period, hospital insurance pays for all covered inpatient hospital services for as many as 60 days after the \$92 hospital insurance deductible. If you continue to need inpatient hospital care or need to be hospitalized again during the same benefit period, hospital insurance pays for all covered services for the 61st through 90th day, *except for \$23 a day*.

In addition to 90 inpatient hospital days in one benefit period, you have a lifetime total of 60 inpatient hospital reserve days. Reserve days, however, are **not** renewable. Hospital insurance pays for all covered services *except for \$46 a day* for each reserve day you use. (For more information about inpatient hospital care, see "When you are a hospital inpatient" on page 12 in *Your Medicare Handbook*.)

The hospital insurance deductible and daily amounts apply only to the inpatient hospital days that **you** use. They do not apply to the hospital stay of a person who is donating a kidney for your transplant surgery. Medicare pays for **all** covered services of the donor. The inpatient hospital days used by a kidney donor do not reduce the number of inpatient hospital days that you may use in a benefit period. A kidney donor's inpatient hospital stay does not qualify him or her for other Medicare benefits. But, your hospital insurance will pay for any additional inpatient hospital care your donor might need if there are complications that are a direct result of the kidney donation.

Medicare's hospital insurance payments are made directly to the hospital.

What medical insurance pays for

Medicare's medical insurance covers your surgeon's services for performing the kidney transplant operation. This includes pre-operative care, the surgical procedure, and follow-up care. Medical insurance also covers physicians' services provided to your kidney donor during his or her inpatient hospital stay while you are receiving a kidney transplant.

After the \$60 annual medical insurance deductible is met, Medicare's medical insurance pays 80 percent of the recognized charge for your surgeon's services and the physicians' services provided to your kidney donor.

Some approved hospitals will include your surgeon's fee in their costs for your transplant surgery. In this case, if the \$60 annual deductible has already been met, Medicare pays the hospital for your surgeon's services except for 20 percent of the surgeon's fee. Otherwise, medical insurance payments for your surgeon's services are paid as explained in *Your Medicare Handbook* (see "How medical insurance payments are made" on page 23 of the handbook).

How Medicare pays for blood

Both parts of Medicare can help pay for blood (or equivalent units of packed red blood cells).

Hospital insurance covers the costs of any blood you may need during a covered inpatient hospital or skilled nursing facility stay, except for the first 3 pints of blood in each benefit period.

If you receive blood in connection with services covered by medical insurance, medical insurance pays for the blood, except for the first 3 pints in each calendar year. After the first 3 pints, medical insurance pays 80 percent of the recognized charges less any part of the \$60 annual deductible that is not met. If you are receiving maintenance dialysis as an outpatient of an approved hospital dialysis center, any blood you need will usually be covered by medical insurance as part of the costs of your dialysis treatment. Blood you need can also be covered by medical insurance when it is provided as a part of a physician's service and included by the physician in the charge for the service.

Medicare does not cover blood in connection with self-dialysis at home unless it is provided as part of a doctor's service or is needed solely for the purpose of priming the dialysis equipment.

If you are a member of a blood donor plan, it can usually replace the blood that is not covered by Medicare. Or, you can often arrange to have someone donate blood for you.

What Medicare does not cover

The following list shows some of the services and supplies that Medicare does **not** cover in connection with dialysis and transplant services. Pages 42 and 43 in *Your Medicare Handbook* list other services and supplies which are not covered by Medicare.

Alcohol, gauze and similar first-aid supplies for home use

Lodging costs when an outpatient dialysis facility is not near your home

Dialysis aides' services to assist in home dialysis

Primary transportation costs to a facility for outpatient maintenance dialysis

Drugs and medicines you buy yourself with or without a prescription

Travel costs to you and partner during training

HD 7106 .U5 Y68 SUPP.

Your medicare handbook.



3 8095 00011066 4

Other payment sources

If you have health care protection from another source—for example, from private health insurance, from the Veterans Administration, the Indian Health Service, or a Federal employee's health plan—we suggest you get further information concerning their payment for services needed for the treatment of permanent kidney failure.

There are also agencies in some States that, under certain conditions, help with some of the medical expenses that Medicare does not cover. Some States have Kidney Commissions which are agencies that help people who need assistance in meeting expenses of kidney dialysis and transplant services that Medicare cannot pay.

Every State has a Medicaid program that helps pay medical expenses in cases of financial need.